

2025 Enrollment Request Form

☐ UHC Complete Care Support MN-8 (PPO C-SNP) H2001-134-000

| Last name | type or print in black or blue ink | | | Middle initial | |
|--|------------------------------------|-------------------|---------|-------------------------|--|
| Birth date | | Sex □ Male □ | Femal | e | |
| Home phone number () | _ | Mobile phone nu | umber (| () – | |
| ☐ I give consent for UnitedHealthcausing an autodialer and/or prerecor | | • | one nur | mber(s) I have provided | |
| Medicare number | | | | | |
| Permanent residence street address homelessness, a PO Box may be o | • | | | | |
| City | County | 5 | State | Zip code | |
| Mailing address (Only if it's differe | nt from above | e. You can give a | P.O. bo | x.) | |
| City | | (| State | Zip code | |
| Email address (optional) | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Enrollee name | | | | | |
| Agent name/ID number | | | | | |
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| Do you have other insurance (Examples: Other private insura programs.) If yes, what is it? | | • | ☐ Yes ☐ No benefits or state | | |
|---|---|---------------------|---------------------------------|--|--|
| Name of other insurance | | | | | |
| Member number | Group number | RxBin | RxPCN (optional) | | |
| Answering these questions is fill them out. | your choice. You can't be de | enied coverage b | ecause you don't | | |
| How do you want to pay? If you have a monthly plan prer pay your premium by automatic Board (RRB) benefit check each Electronic Funds Transfer (EFT) | nium (including any late enroll c deduction from your Social S ch month. You can also pay fro | Security or Railroa | d Retirement | | |
| If you don't choose an option b | elow, we'll send a bill each mo | onth to your mailir | ng address. | | |
| If you must pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), | | | | | |
| Social Security (SS) will send y | ou a letter and ask you how yo | u want to pay it: | | | |
| ☐ You can pay it from your SS check | | | | | |
| ☐ Medicare can bill you | | | | | |
| ☐ The Railroad Retiremen | t Board (RRB) can bill you | | | | |
| ☐ I want to pay from my Social | Security check | | | | |
| ☐ I want to pay from my Railro | ad Retirement Board (RRB) ch | neck | | | |
| ☐ I want to pay directly from a bank account | | | | | |
| Account type ☐ Checking ☐ Savings | | | | | |
| Account holder name: | | | | | |
| Bank routing number/// | | | | | |
| Bank account number_/_/_/_/_/_/ | | | | | |
| | | | | | |
| A few questions to help u | s manage your plan | | | | |
| 1. Would you prefer plan info | rmation in another language | or an accessible | format? | | |
| | rmation in another language or Braille Large print Audi | | • | | |
| Enrollee name | | | | | |
| Agent name/ID number | | | | | |
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If you don't see the language or format you want, please call us toll-free at **1-866-367-7527**, TTY **711**, 8 a.m.-8 p.m. local time, 7 days a week. Or visit **UHC.com/Medicare** for online help.

| 2. Are you Hispanic, Latino/a, or Spanish | |
|--|---|
| No, not of Hispanic, Latino/a, or Sp | • |
| Yes, Mexican, Mexican American, o | or Chicano/a |
| Yes, Puerto Rican | |
| Yes, Cuban | |
| Yes, another Hispanic, Latino, or Sp | panish origin |
| I choose not to answer | |
| 3. What's your race? Select all that apply | |
| American Indian or Alaska Native | Black or African American |
| Asian: | Native Hawaiian or Pacific Islander: |
| Asian Indian | Guamanian or Chamorro |
| Chinese | Native Hawaiian |
| Filipino | Samoan |
| Japanese | Other Pacific Islander |
| Korean | |
| Vietnamese | White |
| Other Asian | I choose not to answer |
| • | e recognized Tribe (name of Tribe) |
| 4. What is your gender? Select one Woman | Luca a different term |
| Woman | I use a different term: |
| Non-binary | I choose not to answer |
| Non-binary | I choose not to answer |
| 5. Which of the following best represents | how you think of yourself? Select one. |
| Lesbian or gay | I use a different term: |
| Straight, that is, not gay or lesbian | I don't know |
| Bisexual | I choose not to answer |
| 6. Do you or your spouse work? | □ Yes □ No |
| Do you or your spouse have other health in | surance that will cover medical services? |
| (Examples: Other employer group coverage | |
| auto liability, or Veterans benefits) | ☐ Yes ☐ No |
| If yes, please complete the following: | |
| Enrollee name | |
| Agent name/ID number | |
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| Page | 4 | of | 8 | |
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| | | | Page 4 of 8 |
|--|---|--|---|
| Name of health in | nsurance company | | |
| Member number | | | |
| 7. Please give us | the name of your primary care | provider (PCI | P), clinic or health center. |
| | to this list. You may go to any do | octor who acce | pts Medicare and the plan's |
| payment terms. You can find a list | on the plan website or in the Pr | ovider Director | y. |
| | · | | • |
| Provider or PCP for | | | |
| Provider/PCP nur | nber | the website o | the number exactly as it appears on or in the Provider Directory. It will be s. Don't include dashes.) |
| Are you now seeir | ng or have you recently seen this | s provider? | ☐ Yes ☐ No |
| Providing your er | | ılly enrolls you | in paperless delivery for some of |
| an email when ne | w communications (For example ilable online. You can access the | e: Explanation o | ed electronically. We will send you of Benefits or the Annual Notice of ations through any device such as a |
| If you would rath | er have hard copies of require | d materials ma | ailed to you, please check here: |
| some commun | erless delivery, we will mail you h ications are very large and may delivery at any time. | • | equired materials. Please note that ilboxes. You can change your |
| Please read an | | | |
| By completing th | is form, I agree to the following | g: | |
| paying my Pa I understand the country, e urgent care of I understand prescription of UnitedHealthe (also known a | art B premium if I have one, unle that people with Medicare are g except for limited coverage near outside of the U.S. See the Sumr that when my UnitedHealthcare drug benefits from UnitedHealth care and contained in my United | ss Medicaid or enerally not co the U.S. borde nary of Benefits coverage beging are. Benefits all Healthcare "Evber agreement | evered under Medicare while out of er. This plan covers emergency and is for more information. Ins, I must get all of my medical and and services authorized by vidence of Coverage" document by will be covered. Neither Medicare |
| | | | |
| Agent name/ID nui Y0066_ERFMA_2025_ | mber C | | UHMN25LP0221008_000 |
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| that en | rollment in this plan will auto | matically end my enrollme | ntage (MA) plan at a time – and nt in another MA plan (exceptions | | | | |
|---|---|---|---|--|--|--|--|
| apply f plans). | or MA Private Fee-for-Service | e (PFFS), MA Medicare Med | dical Savings Account (MSA) | | | | |
| Release will sha payme information | are my information with Medionts, and for other purposes a ation (see Privacy Act Statem | care, who may use it to tradullowed by Federal law that tent below). | authorize the collection of this | | | | |
| | or person(s) for permissible purposes under applicable law as required to administer my health | | | | | | |
| The inf intention | ormation on this form is corre enally provide false information ponse to this form is voluntar | on on this form I will be dise | • | | | | |
| When I sig | n below, it means that I have | e read and understand the | e information on this form | | | | |
| behalf of the received my UnitedHealth Signature of | e member beyond this applic y UnitedHealthcare UCard®, thcare UCard to update my a of applicant/member/autho | cation. After this application I can call Customer Service authorization information or crized representative | Today's date | | | | |
| _ | the authorized represe on below (*Not a Sales A | | bove and complete the | | | | |
| Last name | | First name | | | | | |
| Address | | | | | | | |
| City | | State | Zip code | | | | |
| Phone number () — Relationship to applicant | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| Enrollee nan | ne | | | | | | |
| | ne | | | | | | |

| For individuals hel | ping enrollee with | comi | olet | ing this form o | nlv |
|--|--|-------------------|-----------------------------|--|--|
| Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family | | | | | |
| members, or other third parties) helping an enrollee fill out this form. | | | | | |
| Name | | Relati | ons | hip to enrollee | |
| Signature | | Natio | nal F | Producer Number | (Agents/Brokers only) |
| For Licensed Sales | s Representative/ | agend | y u | se only | |
| Licensed Sales repres | entative/Writing ID | | Initial receipt date | | е |
| Licensed Sales repres | entative/agent name | | Proposed effective date | | ve date |
| Employer group name | | | | | |
| Employer group ID | | | В | ranch ID | |
| Agent must complete IEP (MA-PD enrollees) OEP (Newly eligible) SEP (Chronic) SEP (SEP reason) | ☐ ICEP (MA enrolled ☐ SEP (Dual LIS change of status) ☐ SEP (Dual LIS maintaining) | e 2 C re | nrol nd I SE eside | P (MA-PD lees eligible for EP) EP (Change in ence) EP (October 15- mber 7) | ☐ OEP (Jan 1 - Mar 31) ☐ SEP (Loss of EGHP coverage) ☐ OEPI |
| Enrollee name Agent name/ID number | | | | | |
| Y0066_ERFMA_2025_C | | | | | UHMN25LP0221008_000 |

Licensed Sales representative signature (optional)

Date

Please mail or fax this completed form to:

UnitedHealthcare P.O. Box 30770 Salt Lake City, UT 84130-0770

Fax: 1-888-950-1170
Fax the front and back of each page

PRIVACY ACT STATEMENT: The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

UHC Complete Care Support MN-8 (PPO C-SNP) is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare.

This information is available for free in other languages. Please call our customer service number located on the back cover of this book.

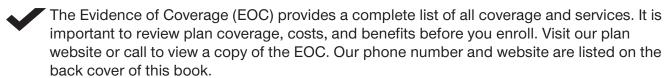
Esta información está disponible sin costo en otros idiomas. Comuníquese con nuestro número de Servicio al Cliente situado en la contraportada de este libro.

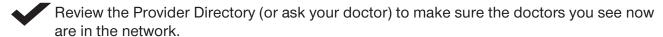
OMB No. 0938-1378 Expires: 6/30/2026 Y0066_ERFMA_2025_C

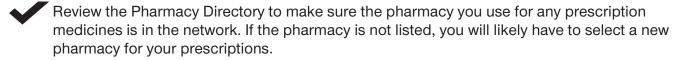
Enrollment checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Customer Service Representative at the number listed on the back cover of this book.

Understanding the benefits





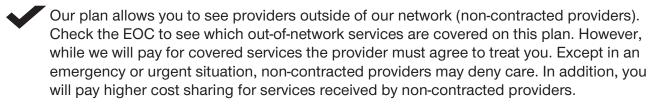


Review the Formulary to make sure your drugs are covered.

Understanding important rules







Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage health care coverage will end once your new Medicare Advantage coverage starts. If you have TRICARE, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact TRICARE for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

This plan is a Chronic Condition Special Needs Plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.